Kathryn Doheny, PsyD

Licensed Clinical Psychologist

312.409.0899 | kathryn@doheny.com

307 N. Michigan Ave Suite 802, Chicago, IL 60601

INFORMATION ABOUT PSYCHOTHERAPY

Welcome and I look forward to meeting you at our first session. The following pages cover important details regarding the process of therapy as well as confidentiality issues. It is important that you are informed regarding the risks and benefits of our work together. They also outline payment details which need to be addressed before getting started. It is essential you read these pages carefully as your signature on the Signature Page indicates you have done so and agree with these practice policies. There is no need to print or bring this form to our first visit. It is for your information only and these details will remain on my site as a source for your future reference.

INSURANCE

Please also read the Insurance and Payment page on this website carefully. I am in network with Blue Cross Blue Shield PPO plans. I would be considered out of network with all other carriers and can supply a billing statement for you to submit to your insurance company for reimbursement. If you expect insurance to pay for part of your session, it is your responsibility to ensure that you are and remain covered by that payer. You will be charged it BCBS does not pay your bill.

PAYMENTS

- **Fees, coinsurance or copays:** Due at time of appointment.
- **Deductibles:** If there is a deductible, or you have an out-of-state Blue Cross policy, I may require that you fill out the credit card payment form to have on file.
- **Means of Payment:** I accept cash, check or charge.
- **Cash or Check:** I prefer to be paid with cash or check. Please make out check beforehand to save time during session.
- **Credit Card Payments:** If you prefer, I accept Visa and Mastercard debit cards, as well as Visa, Mastercard and Discover credit cards. There is a 3.5% convenience fee to use this form of payment. Charges will show on your statement as professionalcharges.com. I ask that charge amounts be at least $40. Fill out the credit card form before your first session.
- **Receipts:** If you would like a receipt, please let me know.

CANCELLATION/NO-SHOW POLICIES AND FEES

- **Cancellation: If you need to cancel, please call at least 24 hours ahead, otherwise you will be charged the full session fee.**
- **Illness:** If you have a crisis or illness and can't attend your appointment, call me and we will discuss it.
- **No-show Fee: If you do not show up for your appointment and do not call, you will be charged the full session fee.**

LATENESS

Please come on time. Due to scheduling of others' appointments, I am unable to extend past the usual time. Your full fee will be due even if you are late.

NON-PAYMENT OF FEES

If you have not paid your psychotherapy fees and do not respond to my attempts to contact you, I reserve the right to forward any past due amount to collections. By coming to see me, you agree to this policy.

PHONE MESSAGES

I check my messages at least once each day. I will attempt to return any message you leave for me within 24 hours of getting it. Routine messages left on Saturday or Sunday will be returned on Monday. I am not available by phone after 7 pm or before 9 am. There will be a charge for lengthy phone consultations.

AVAILABILITY

I am not available at all times. If you think this will be a problem, please ask me for a referral to someone else who may meet your needs better.

EMAIL

Please feel free to communicate with me about routine matters by email. My email address is kathryn@doheny.com. I typically check respond to my emails in 1-2 days. If your matter needs more timely attention, please call instead. I will do my best to assure your confidentiality through email, but due to viruses, hackers, etc., no email correspondence can be guaranteed to be confidential. Do not send information that you would consider to be sensitive information through email.

If any of these policies do not worked for you, please let me know, I will attempt to refer you to someone who may be able to meet your needs better.

INFORMED CONSENT

What is Informed Consent? Informed consent is the process of you learning about psychotherapy and its risks and benefits. It's also an opportunity to learn what my practice policies are and about confidentiality. Part of the informed consent process is provided to you in written form so that you don't miss anything important. Over time, as I get to know you better, I will talk to you about what types of treatment I think would be most helpful and we will talk about this. That is part of the informed consent process as well.

Your Involvement: For the best possible results in psychotherapy, it will be necessary for you to take an active role in your treatment. Gaining more insight regarding thoughts, feelings, and patterns of behavior is often a byproduct of therapy. Changes and shifts often accompany deeper awareness in all three areas.

Length and Frequency of Therapy: At first, you should attend on a weekly basis. Some problems can be improved in 2-3 months of therapy. Other problems need longer term treatment.

Ending Therapy: It is best if we decide together when to end your therapy. However, if you wish to stop therapy at any time, please tell me in advance and attend at least one more session. If you would like to take a "time out" from therapy, please let me know.

Risks of Therapy: Therapy is not always a comfortable process and may lead to shifts in thinking, feeling, communicating and behaving. Sometimes this is disruptive in relationships. We will work together to address changes that you notice and to manage these in a way that works best for you.

Benefits of Therapy: The benefits of therapy have been shown by scientists in hundreds of well-designed research studies. My goal is to engage you in reflecting on your life and any ways it could possibly feel better. It may be symptom management, improved relationships, more effective communication skills or a desire for a more content and happy life.

Additional and Alternative Treatments: If you could benefit from a treatment I do not provide then we will talk about that option and I can make a referral to another therapist or psychiatrist.

The Therapeutic Relationship: As a psychologist I am required to follow the professional standards of my field which puts ethical limits on the relationship between therapist and client. To maintain privacy, I will do my utmost to not reveal you are a client.

- Unless we have a different agreement, I will generally not greet you or acknowledge that we have a professional relationship.
- I cannot attend your personal events as this could compromise the confidential nature of our relationship.
- When I become your therapist, I am unable to have any other role in your life (ie friend, business partner). I am also unable to 'friend' you on any social media sites.

No Court Testimony: If you ever become involved in a divorce, custody dispute, or any other legal matter, I will not provide evaluations or expert testimony in court. Your signature indicates your agreement with this provision.

Subpoena: If I am, for any reason, subpoenaed or otherwise required to participate in a legal proceeding as a result of providing professional sevices to you, you will be responsible for paying me a forensic rate of $250 an hour for all time expended on your case. This includes phone calls, preparation, record copying and mailing, travel time, time testifying and time waiting in court.

Complaint Procedures: If you are not satisfied with an area of our work, please raise your concerns with me at once. Our work together will be slower and harder if your concerns with me are not worked out. I will make every effort to hear any complaints you have and to seek solutions to them. If you feel that I, or any other therapist, has treated you unfairly or has even broken a professional rule, please tell me.

Emergencies: If you are feeling suicidal, do not call me, since I may not be available 24/7. Instead, it is your responsibility to seek out help immediately. Go to your nearest emergency room or call 911.

CONFIDENTIALITY

I will treat what you tell me with great care. My professional ethics and the laws of this state prevent me from telling anyone else what you tell me unless you give me written permission except in certain specific situations that I list below. These rules and laws are the ways our society recognizes and supports the privacy of what we talk about—in other words, the confidentiality of therapy. But I cannot promise that everything you tell me will never be revealed to someone else. The HIPAA Notice of Privacy Practices (next page) provides details about these limits to confidentiality. Please review it carefully.

Releasing Your Health Information: If you want me to send information out of my office, or I need information about you from someone else, or I need to coordinate your health care with another professional, I will ask you sign a release of information form. You can see this form on my website. This form states exactly what information is to be shared, with whom, and why, and it also sets time limits. If you have questions, please ask me.

Legal Limits to Confidentiality: (1) If my assessment is that you are at high and immediate risk of committing suicide, and you refuse to go to a hospital, I may need to ask the police to take you to a hospital and/or contact someone close to you—perhaps a relative, spouse, a close friend. I will also need to alert the State of Illinois. However, please realize that most people who think about suicide or who think that they might be better off dead are not at high or immediate risk of committing suicide and I will not hospitalize them or make any reports. (2) Also, I need to contact the State of Illinois authorities if you are at serious risk of harming someone else or if you have exhibited threatening behavior towards that person. (3) If you have harmed or abused a child or elderly person or exploited or neglected them in any way, I must contact the appropriate State of Illinois authorities. (4) The fourth legal limit is highly unlikely to apply to you but involves reporting individuals who are developmentally or intellectually disabled to the degree that is a substantial handicap or impairs adaptive behavior.

Professional Consultation: I Sometimes consult other psychotherapists. This helps me give high-quality treatment. These persons are also required to keep your information private. Your name will never be given to them, and they will be told only as much as they need to know to understand your situation.

Back-Up Therapeutic Coverage: When I am away from the office for a few days, I have a trusted fellow psychotherapist cover for me. This therapist will be available to you in emergencies. He or she may need to know about you. Of course, this therapist is bound by the same laws and rules as I am to protect your confidentiality.

Professional Educational Use of Case Materials: As a therapist, I naturally want to know more about how therapy helps people. I would be grateful for your consent to use your case material in my other professional activities. Your material may help in the development of the mental health field or in the training of health care workers. It is possible that I may use some information about your treatment in teaching, supervision, consultation with other therapists, publishing, or scientific research. You would not get any financial benefit from this. When I use information from my therapy work, I do not want anyone who hears, reads, or sees it to be able to identify the clients involved. Therefore, I conceal your identity by changing your identifying information and I will also typically merge your information with that of a client who has similar difficulties. If you do not agree to the uses of case materials as indicated, you will not be penalized in any way, and it will not affect the care you receive in any way. You may draw an X through this section on the signature page if you do not want your case materials used in this way.

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: July 1, 2013

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact me.

MY OBLIGATIONS.

I am required by law to (1) maintain the privacy of protected health information, (2) give you this notice of our legal duties and privacy practices regarding health information about you, and (3) follow the terms of my notice that is currently in effect.

HOW I MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways I may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, I will use and disclose Health Information only with your written permission. You may revoke such permission at any time in writing.

For Payment. I may use and disclose Health Information so that I may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, I may send your health plan information about you, including a diagnosis, so that they will pay for your treatment. Insurers such as Blue Cross/Blue Shield or managed care organizations on rare occasions may ask for additional information about you and your symptoms. I have no control over how these records are handled at the insurance company. My policy is to provide the minimum amount of information that the insurance company needs to pay your benefits.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, I may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. Unless it is an emergency, I will first ask you to fill out a release of information form and we will discuss what information will be shared with your family member or close friend.

SPECIAL SITUATIONS

As Required by Law. I will disclose Health Information when required to do so by international, federal, state or local law.

Abuse and Neglect Reporting. I may disclose Health Information to report child abuse or neglect, and elder abuse or neglect.

To Avert a Suicide or Violence/Homicide. I may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. If such a situation does come up, I will fully discuss the situation with you before I do anything, unless there is a very strong reason not to. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Health Oversight Activities. I may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. That said, to date, I have never had to make any disclosures of this type.

Data Breach Notification Purposes. I may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, I may be required to disclose Health Information in response to a court or administrative order. I also may be required to disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. I may be required to release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, I are unable to obtain the person's agreement; (4) about a death I believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities. If mandated to do so, I will release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. Or to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT.

In all instances, unless mandated by law or noted above, I will obtain your written permission before releasing your Protected Health Information, so opting out and objecting to uses and disclosures would not be needed.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation and I will no longer disclose Protected Health Information under the authorization. But disclosure that I made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS.

You have the following rights regarding Health Information I have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing. I have up to 30 days to make your Protected Health Information available to you and I may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. I may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. I may deny your request in certain limited circumstances. If I do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and I will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. I will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. I may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information I have is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for my office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures I made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information I use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information I disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that I not share information about a particular diagnosis or treatment with your spouse. To request a restriction, please specify this restriction in writing on your release of information form.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that I not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and I will honor that request.

Right to Request Confidential Communications. Unless you tell me otherwise, I will usually contact you through your cell phone and/or your email address. Occasionally, I may use your home or work phone numbers, if you gave them to me. You have the right to request that I communicate with you about mental health matters in a certain way or at a certain location. For example, you can ask that I only contact you by mail or at work. To request confidential communications, you must make your request, in writing. Your request must specify how or where you wish to be contacted. I will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may download a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at www.drkathryndoheny.com. To obtain a paper copy of this notice, just ask.

FOR YOUR INFORMATION

One Set of Progress Notes. Some psychotherapists maintain two sets of progress notes about your treatment. I do not do that, unless there is a compelling reason to do so. If I will keep two sets of notes, I will let you know. If there are two sets of notes, the set that contains more details about your personal situation (called “psychotherapy notes”) would require separate authorizations from you to disclose.

No Marketing, Sale or Fund-raising. I will never use your information for marketing purposes, nor will I sell your information, nor use it for fund raising. Any health organization that does any of these things would need your authorization.

CHANGES TO THIS NOTICE

I reserve the right to change this notice and make the new notice apply to Health Information I already have as well as any information I receive in the future. I will post a copy of my current notice on my website. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be penalized for filing a complaint.

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SIGNATURE PAGE

Information about Psychotherapy Handout

I have received and read the handout entitled Information about Psychotherapy and agree to abide by Dr. Doheny's practice policies. If at any time I have any questions about the subjects discussed in this handout, I can talk with Dr. Doheny about them. I also understand that I can review this information at any time at Dr. Doheny's website, www.drkathryndoheny.com. My signature does not indicate that I am waiving any rights. I understand that I have the right not to sign this form.

HIPAA Notice of Privacy Practices Handout

I have received and read the handout entitled HIPAA Notice of Privacy Practices. My signature below shows that I understand how my personal health information may and may not be disclosed by Dr. Doheny.

Case Materials

I give Kathryn Doheny, Psy.D. my permission to use her knowledge of my psychotherapy work for research, teaching, writing and other professional purposes that involve educating mental health professionals and students. I understand that my name will never be used, my information will always be disguised, and in almost all cases, my information will be merged with details from other individuals. (Please X out this paragraph if you do not agree to it).

Cancellation and No-Show Policy

My signature below shows that I understand and agree to comply with the cancellation/no-show policy. I understand that unless Dr. Doheny and I agree to something different, I am responsible for the full session fee ($150.00) if I do not show up for an appointment or cancel with lass that 24 hours notice.

I also understand and agree that I will not call Dr. Doheny as a witness in a court of law regarding divorce, child custody or any other legal matter.

_____ _____

Signature of Client Date

_____

Printed Name

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CLIENT INFORMATION/CONCERNS CHECKLIST

Date: _____

Client Name: _____ Current Age: _____

Address: _____

_____

City State Zip Code

_____ _____ _____

Home Phone Cell Phone Work Phone

e-mail: _____ Can I email you at this address? Y__N___

If Married, Name of Spouse: _____

If Children, Names/Ages of Children: _____

Occupation/Employer Name: _____

If possible, please provide name/phone number of Primary Care Physician. I will inform you if coordination of care is needed. _____

How did you hear about me? _____

INSURANCE INFORMATION

Policy Holders name (yourself, your spouse, or your parent). _____

Policy Holder's Relationship to Client: _____

Policy Holder's Member ID #: _____ Policy Holder's DOB: _____
(please include letter prefix as displayed on card)

Client's DOB: _____

Group Plan: _____ Insurance Company Phone Number: _____

CONTACT PERSON IN CASE OF EMERGENCY

Name: _____ Phone:_____

Email: _____ Relationship to you: _____

INFORMATION CHECKLIST

Please review the following list of treatments you may have had in the past. Put a check next to any that apply to you and indicate the dates to the best of your recollection.

	Dates
Inpatient psychiatric hospitalization	_____
Intensive outpatient treatment	_____
(2+ days per week)	_____
Psychotherapy	_____
Outpatient Substance Abuse counseling	_____
Attending AA/NA/CA meetings	_____
Taking medication for sleep	_____

PSYCHOTROPIC MEDICATIONS

Are you taking any psychotropic medications? If so, please list including dosages. _____

_____

Psychiatrist name and phone:

_____

MEDICAL HISTORY

Please list all current medical problems you have. Be sure to include chronic conditions such as asthma, seizure disorder, arthritis, diabetes etc. _____

_____

Please list your current level of physical pain on a scale of 0-10, 0 being no pain 10 being the worst._____

HEAD INJURY

Have you ever been hit or injured on the head? Y_____ N_____

Have you ever been knocked unconscious? Y_____ N_____

Please describe: _____

_____

HEALTH HABITS

What kinds of physical exercise do you get?_____

_____

How many times per week do you typically exercise for 20 minutes or more?_____

_____

What is your average number of hours of sleep per night?_____

HISTORY OF EVENTS

Please indicate any of the following events that may have occurred to you in the past.

_____ My parents/caretakers punished me physically as a child or teenager,

_____ My parents/caretakers were verbally harsh and critical of me as a child or teenager

_____ My parents/caretakers did not provide appropriate supervision, food, shelter or other protection

_____ My parents/caretakers were unaware of my difficulties when I was a child or teenager

_____ I experienced inappropriate sexual harassment as an adult

_____ I experienced other upsetting sexual experiences as an adult

_____ As an adult, I experienced a physical injury intentionally caused by another adult

PRESENT RELATIONSHIP

_____ I do not have a partner at present

How would you characterize your relationship with your partner (conflictual, supportive etc) _____

_____

USE OF CAFFEINE, ALCOHOL, TOBACCO AND STREET DRUGS

How much coffee, cola, tea or other sources of caffeine do you consume each day? _____

Have you ever felt the need to cut down on your drinking? Y_____ N_____

Have you ever felt annoyed by criticism of your drinking? Y_____ N_____

Have you ever felt guilty about your drinking? Y_____ N_____

How much beer, wine or hard liquor do you consume each week on average? _____

How much tobacco do you smoke each week? _____

Which street drugs have you used in the last 3 years? _____

LEGAL ISSUES

Are you currently suing anyone or thinking of suing anyone? If yes, please explain: _____

_____

_____

Is your reason for coming to see me related to an accident or injury? If yes, please explain; _____

_____

_____

Are you required by a court, the police or a probation or parole officer to have this appointment? _____

_____

_____

Have you had any contact with the police, courts, jails/prisons regarding a crime you were charged with?

Y_____ N_____

Are there any other legal involvements I should know about? If so, please describe: _____

_____

_____

EDUCATION/TRAINING

What is your highest level of education or specialized training? _____

_____

CHECKLIST OF CONCERNS Please mark all that apply to you.

PROBLEM AREAS:

_____ Aggression toward others
_____ Aggression toward me
_____ Career concerns, goals, choices
_____ Divorce, separation
_____ Financial or money troubles, debt, impulsive spending, low income
_____ Friendships
_____ Grieving, mourning, deaths, losses
_____ Headaches, neck or back pain
_____ Identity Issues
_____ Infidelity, affairs
_____ Interpersonal conflicts
_____ Job Stress
_____ Legal matters, charges, suits
_____ Loneliness
_____ Menstrual problems, PMS
_____ Procrastination, work problems
_____ Relationship conflict
_____ Relationship problems
_____ School problems
_____ Pain, chronic
_____ Parenting Issues
_____ Sexual issues with partner
_____ Other sexual problem
_____ Work problems, overworking, can't keep a job

EMOTIONAL CONCERNS:

_____ Feeling unsafe, even in safe situations
_____ Anger, hostility
_____ Distressing memories of the past
_____ Nightmares or upsetting dreams
_____ Suspiciousness
_____ Anxiety, nervousness
_____ Agitated
_____ Fear
_____ Obsessive thoughts
_____ Panic or anxiety attacks
_____ Phobias (please specify: _____)
_____ Shyness
_____ Tension, can't relax
_____ Attention, concentration, problems with one or both
_____ Confusion
_____ Distractibility
_____ Memory problems
_____ Depression, low mood, sadness, crying
_____ Emptiness feelings
_____ Failure feelings
_____ Fatigue, tiredness, low energy
_____ Guilt
_____ Inferiority feelings
_____ Motivation problems
_____ Mood swings
_____ Oversensitivity to rejection
_____ Oversensitivity to criticism
_____ Perfectionism
_____ Self Esteem problems
_____ Sexual drive, lack of
_____ Suicidal thoughts
_____ Feeling that others are out to get me
_____ Feeling that others are watching me
_____ Hearing voices
_____ Impulsiveness
_____ Irresponsibility
_____ Judgment problems, risk taking

BEHAVIORAL ISSUES:

_____ I have had a DUI (When? _____)
_____ Aggressive or violent thoughts or behaviors
_____ Excessive arguing
_____ Compulsive behaviors (Please specify: _____)
_____ Cutting or otherwise injuring self
_____ Decision making problems, indecision, mixed feelings, procrastinating decisions
_____ Disorganization
_____ Eating problems—overeating, undereating, vomiting
_____ Gambling
_____ Irritability
_____ Self neglect, poor self care
_____ Sleeping too much
_____ Sleep problems—too little sleep, insomnia, frequent awakenings
_____ Temper problems, self control, low frustration tolerance
_____ Weight and diet issues, or unplanned gain or loss
_____ Withdrawal, isolating

Any other concerns or issues: _____

_____

_____

Which concerns do you most want help with? _____

_____

_____